

FILED NOV 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37277

STATE FILE NUMBER

318

1003

10419

Registration District No.

Primary Registration District No.

Registration No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Length of stay in 1b		d. STREET ADDRESS 4966a Oleatha Ave. (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First POLIXENI Middle NMN Last CASSIMATIS				4. DATE OF DEATH Month Nov. Day 2 Year 1957					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 10, 1882		9. AGE (In years last birthday) 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Greece				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nickolas Mentis				14. MOTHER'S MAIDEN NAME Helen Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Philip Monypenny 4966a Oleatha Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Appendicitis Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 550.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 8-9 Days	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from 10/25/57 to 11/2/57 and last saw her/him alive on 11/2/57 . Death occurred at 9:10 P. m. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE C. D. Vermillion, M.D. (Degree or title)				22b. ADDRESS BARNES HOSPITAL				22c. DATE SIGNED 11/3/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 5, 1957		23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cem.		23d. LOCATION (City, town, or county) St. Louis, Mo. (State)			
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway ADDRESS				25. DATE RECD. BY LOCAL REG. NOV 4 57		26. REGISTRAR'S SIGNATURE J. Carl Smith MD mjb			

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by Student Embalmer No.
working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 302

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.